Attachment C

STATE OF IOWA
DEPARTMENT OF ADMINISTRATIVE SERVICES – HUMAN RESOURCES ENTERPRISE
DONATED LEAVE FOR CATASTROPHIC ILLNESS
IMMEDIATE FAMILY MEMBER
CONTRIBUTIONS

Part A. TO BE COMPLETED BY THE DONATING EMPLOYEE:

I, _____, agree to donate a total of _____ hours of my accrued leave

(_____ vacation; _____ compensatory time; _____ holiday compensatory time) to:

_____ employed by _____
(Recipient) *(Recipient's Department)*

I understand that this contribution of my accrued leave is irrevocable and cannot be reversed or changed once it is credited to the RECIPIENT.

_____ _____
(Signature of Donating Employee) ***(Date)***

Part B. TO BE COMPLETED BY THE DONATING EMPLOYEE'S PERSONNEL ASSISTANT:

Donor's Name: _____ SSN: _____

Department: _____ Payroll #: _____

_____ _____
(Signature of Personnel Assistant) *(Date)*

Personnel Assistant: Please forward a copy of this form to the RECIPIENT'S personnel assistant. A copy of this form will be returned to you when the donation is credited to the RECIPIENT.

Part C. TO BE COMPLETED BY THE RECIPIENT'S PERSONNEL ASSISTANT:

Recipient's Name: _____ SSN: _____

Department: _____ Payroll #: _____

Form Received: _____ AND _____
(Date) *(Time)*

Leave donations to be credited in the pay period(s) beginning on: _____
(Date)

_____ _____
(Signature of Personnel Assistant) *(Date)*

Personnel Assistant: Please forward a copy of this form to the DONOR'S personnel assistant (listed above) **PRIOR to the pay period in which the donation is to be credited**.

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